

Indian Point 3

4Q/2013 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2013

Identified By: Self-Revealing

Item Type: FIN Finding

Inadequate Maintenance Procedure Results in a Reactor Trip

A self-revealing finding of very low safety significance was identified when Entergy personnel did not use a procedure appropriate to the task for testing of a secondary plant valve, resulting in a transient that led to a manual reactor trip. On February 13, 2013, with Unit 2 at full power, Entergy personnel started testing of a heater drain tank dump valve without electrical isolation and other risk management precautions. When energized control power leads were lifted as specified in the work instruction, two electrically inter-connected valves opened causing loss of heater drain flow to the main feedwater pumps. The transient affected steam generator level and operators initiated a rapid down power followed by a manual reactor trip when steam generator level control limits were challenged. The transient was documented in their corrective action program (CAP) as CR-IP2-2013-721.

The finding was more than minor because the testing activity resulted in a reactor trip. The inspectors performed a Phase 1 screening in accordance with IMC 0609, "Significance Determination Process" and determined the finding to be of very low safety significance (Green) because all mitigating equipment remained available. The finding had a cross-cutting aspect in the area of Human Performance, Resources, because the licensee did not assure that procedures and other resources were available and adequate to assure nuclear safety, including accurate design documentation and procedures to support the work activity. Specifically, the work instruction used for the testing had not been appropriately planned or implemented when the electrical control power ties to valves outside the work scope was neither planned into the work nor recognized by the workers.

Inspection Report# : [2013002](#) (*pdf*)

Mitigating Systems

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Assess and Manage Risk Associated with Reactor Testing Below Normal Operating Conditions

The inspectors identified an NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.65(a)(4), requirements for monitoring the effectiveness of maintenance, when Entergy did not assess and manage the risk associated with reactor protection testing with Unit 3 below normal operating pressure. Specifically, on March 27, 2013, with Unit 3 just having entered Mode 3 and while raising reactor coolant system (RCS) temperature, required risk management actions were not taken regarding a reactor protection system test, and due to a problem with the test equipment, a low pressure safety injection (SI) actuated. Entergy operators took action to mitigate the SI, and the event was entered into the corrective action program (CAP) as CR IP3 2013 2115. A root cause evaluation was initiated to determine the acceptability of conducting this test with the plant at low pressure in Mode 3 and address extent of condition.

The finding was more than minor because it was associated with the configuration control attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring the availability of systems that respond to initiating events to prevent undesirable consequences. In addition, in accordance with IMC 0612, Appendix E, Example 7.f, had the risk assessment for the testing been done using Entergy's risk procedure, the assessment would have determined the impairment of the low pressure SI interlocks and would have placed the plant in an administrative higher risk condition (Orange). The finding was evaluated using IMC 0609, Appendix K, "Maintenance Risk Assessment and Risk Management Significance Determination Process," and determined to be of very low safety significance (Green) when the risk assessment was performed correctly with the resulting actual incremental core damage frequency deficit determined to be very small, less than $1E-6$. The inspectors determined this finding had a cross-cutting aspect in Human Performance, Work Control, when Entergy personnel did not take risk insights, job site conditions such as the plant pressure, technical specification requirements, and an inaccurate pressurizer level indication into consideration when preparing for testing along with the need for contingencies.

Inspection Report# : [2013003](#) (pdf)

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Identify and Correct a Condition Adverse to Quality Affecting Pressurizer Safety Valves

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action," when Entergy failed to correct a condition adverse to quality associated with the Unit 3 pressurizer safety valves (PSVs).

Specifically, following valve lift setpoint failures in 2005 and 2008, Entergy did not complete a cause determination and establish corrective actions. As a result, a PSV (PCV-468) removed from Unit 3 in 2011, lifted at higher than its setpoint pressure due to spring fatigue. Following the 2011 failure, Entergy performed a cause investigation and initiated a corrective action to include spring rate testing in the inspection of the safety valves.

The finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. In accordance with IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, the finding screened to be of very low safety significance (Green), when all screening questions were answered "no." The inspectors determined that no cross-cutting aspect was applicable to this performance deficiency because this finding was not indicative of current licensee performance.

Inspection Report# : [2013003](#) (pdf)

Significance: G Jun 30, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Maintain Appropriate Procedures for Response to Safety Injection Actuation at Low Temperature

The inspectors identified an NCV of 10 CFR 50, Appendix B, Criterion V, "Procedures," when Entergy did not maintain appropriate written procedures for responding to an inadvertent SI on Unit 3 when below the normal operating RCS temperature. As a result, operators did not comply with procedure requirements when responding to an inadvertent SI event on March 27, 2013. During a review of the event by the inspectors, procedure deficiencies were identified which have the potential to lead to a more significant safety concern. Entergy personnel documented the March 27 event in their CAP as CR IP3-2013-2115 and initiated a root cause evaluation.

The finding was more than minor because, if left uncorrected, the procedure deficiencies have the potential to lead to a more significant safety concern related to exceeding vessel integrity pressure limitations if a charging pump was started in solid conditions below 380°F. In accordance with IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," Exhibit 2, the finding screened to be of very low safety significance (Green), when

all screening questions were answered “no.” The finding was assigned a cross-cutting aspect in the area of Human Performance, Resources, because Entergy staff did not ensure that design documentation and procedures were adequate to assure nuclear safety.

Inspection Report# : [2013003](#) (*pdf*)

Significance:  Feb 15, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Implement an Appropriate Procedure to Ensure That One of Two Strategies Provided Adequate Cooling Water Flow to the SGs per 50.54(hh)(2)

The team identified a non-cited violation (NCV) of Unit 2 Operating License Condition 2.N, Unit 3 Operating License Condition 2.AC, and 10 CFR 50.54(hh)(2) for Entergy’s failure to implement guidance for one of the two strategies intended to maintain or restore core cooling by supplying water to the steam generators.

Entergy’s failure to provide adequate procedural guidance to maintain or restore core cooling is considered a performance deficiency. This finding is more than minor because it is associated with the equipment performance attribute of the Mitigating Systems Cornerstone and affects the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent core damage. In accordance Inspection Manual Chapter 0609, Appendix L, “B.5.b Significance Determination Process,” the team concluded that this finding is of very low safety significance (Green). The team judged that as-found, one of the steam generator fill strategies was unavailable, because on initial implementation, given the assumed severity of plant damage and the procedural inadequacies, the required flow rate to the steam generators would not have been provided. The team determined that this strategy was recoverable, because the equipment would not have been damaged, and the operator likely would request and receive additional direction from emergency management personnel when they became available, such that the required flow rate could be achieved. The team determined that no cross-cutting aspect was applicable to this performance deficiency because this finding was not indicative of current licensee performance.

Inspection Report# : [2013007](#) (*pdf*)

Significance:  Jul 20, 2012

Identified By: NRC

Item Type: VIO Violation

Failure to Protect Safe Shutdown Equipment from the Effects of Fire

The inspectors identified a finding of very low safety significance (Green), involving a cited violation of Indian Point Unit 3 Operating License Condition 2.H to implement and maintain all aspects of the approved fire protection program. Specifically, ENO failed to protect required post-fire safe shutdown components and cabling to ensure one of the redundant trains of equipment remained free from fire damage as required by 10 CFR Part 50, Appendix R, Section III.G.2. In lieu of protecting a redundant safe shutdown train, ENO utilized unapproved operator manual actions to mitigate component malfunctions or spurious operations caused by postulated single fire-induced circuit faults. ENO submitted an exemption request (M1090760993) on March 6, 2009, in which it sought exemption from requirements of Paragraph III.G.2, to permit the use of OMAs upon which it had been relying for safe-shutdown in a number of fire areas. However, several OMAs within the exemption request were denied because ENO failed to demonstrate that the OMAs were feasible and reliable, or to appropriately evaluate fire protection defense-in-depth. ENO's performance deficiency delayed achieving full compliance with fire protection regulations

and adversely affected post-fire safe shutdown. ENO has entered this issue into the corrective program for resolution. The inspectors found the manual actions in addition to roving fire watches in all affected areas to be reasonable interim compensatory measures pending final resolution by ENO.

ENO's failure to protect components credited for post-fire safe shutdown from fire damage caused by single spurious actuation is considered a performance deficiency. The performance deficiency was more than minor because it affected the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to an external event to prevent undesirable consequences in the event of a fire. Specifically, the use of operator manual actions during postfire safe shutdown is not as reliable as normal systems operation which could be utilized had the requirements of 10 CFR 50, Appendix R, Section III.G.2 been met and, therefore, prevented fire damage to credited components and/or cables. The inspectors used IMC 0609, Appendix F, Fire Protection Significance Determination Process, Phase 1 and a Senior Reactor Analyst conducted a Phase 3 evaluation, to determine that this finding was of very low safety significance (Green). This finding does not have a cross cutting aspect because the performance deficiency occurred greater than three years ago when the exemption request was submitted to the NRC on March 6, 2009, and is not indicative of current licensee performance.

Inspection Report# : [2012008](#) (*pdf*)

Significance:  Jul 20, 2012

Identified By: NRC

Item Type: VIO Violation

Failure to Protect Safe Shutdown Equipment from the Effects of Fire

The inspectors identified a finding of very low safety significance (Green), involving a cited violation of Indian Point Unit 2 Operating License Condition 2.K to implement and maintain all aspects of the approved fire protection program. Specifically, ENO failed to protect required post-fire safe shutdown components and cabling to ensure one of the redundant trains of equipment remained free from fire damage as required by 10 CFR Part 50, Appendix R, Section III.G.2. In lieu of protecting a redundant safe shutdown train, ENO utilized unapproved operator manual actions to mitigate component malfunctions or spurious operations caused by postulated single fire-induced circuit faults. ENO submitted an exemption request (M1090770151) on March 6, 2009, in which it sought exemption from requirements of Paragraph III.G.2, to permit the use of OMAs upon which it had been relying for safe-shutdown in a number of fire areas. However, several OMAs within the exemption request were denied because ENO failed to demonstrate that the OMAs were feasible and reliable, or to appropriately evaluate fire protection defense-in-depth. ENO's performance deficiency delayed achieving full compliance with fire protection regulations and adversely affected post-fire safe shutdown. ENO has entered this issue into the corrective program for resolution. The inspectors found the manual actions in addition to roving fire watches in all affected areas to be reasonable interim compensatory measures pending final resolution by ENO.

ENO's failure to protect components credited for post-fire safe shutdown from fire damage caused by single spurious actuation is considered a performance deficiency. The performance deficiency was more than minor because it affected the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to an external event to prevent undesirable consequences in the event of a fire. Specifically, the use of operator manual actions during post-fire safe shutdown is not as reliable as normal systems operation which could be utilized had the requirements of 10 CFR Part 50, Appendix R, Section III.G.2 been met and, therefore, prevented fire damage to credited components and/or cables. The inspectors used IMC 0609, Appendix F, Fire Protection Significance Determination Process, Phase 1 and a Senior Reactor Analyst conducted a Phase 3 evaluation, to determine that this finding was of very low safety significance (Green). This finding does not have a cross cutting aspect because the performance deficiency was not considered indicative of current licensee performance.

Inspection Report# : [2012009](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Nov 08, 2013

Identified By: NRC

Item Type: FIN Finding

PI&R Report Summary

Problem Identification and Resolution

The inspectors concluded that Entergy Nuclear Northeast (Entergy) was generally effective in identifying, evaluating, and resolving problems. Entergy personnel identified problems, entered them into the corrective action program at a low threshold, and in general, prioritized issues commensurate with their safety significance. Entergy appropriately screened issues for operability and reportability, and performed causal analyses that appropriately considered extent of condition, generic issues, and previous occurrences. The inspectors also determined that Entergy implemented corrective actions to address the problems identified in the corrective action program in a timely manner. However, the inspectors identified one violation of NRC requirements in the area of problem evaluation that was not reflective of current performance.

The inspectors concluded that Entergy adequately identified, reviewed, and applied relevant industry operating experience to Indian Point operations. In addition, based on those items selected for review, the inspectors determined that Entergy's self-assessments and audits were thorough.

Based on the interviews the inspectors conducted over the course of the inspection, observations of plant activities,

and reviews of individual corrective action program and employee concerns program issues, the inspectors did not identify any indications that site personnel were unwilling to raise safety issues, nor did they identify any conditions that could have had a negative impact on the site's safety conscious work environment.

Inspection Report# : [2013012](#) (*pdf*)

Last modified : February 24, 2014